

# Care in Hard Times From the Perspective of Elderly Care Workers

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## Abstract

The SARS-CoV-2 pandemic has deepened and reshaped the care crisis both on personal and organizational levels. The study aims at answering how and in what form the symptoms of the care crisis appear in elderly care, which is one of the most important but undervalued fields of professional care. The focus of the study lies on what additional burdens the primarily female employees bear due to performing both paid and reproductive labor at the same time. The primary focus of the qualitative case study, conducted in the summer of 2020 and the spring of 2021, was to explore the effects of the coronavirus pandemic. The preliminary assumption is that the measures to curb the pandemic exacerbated the pre-existing organizational crisis and made it even more visible. Ten semi-structured interviews were conducted in a mid-sized town located in the Southern Great Plain in Hungary with the key stakeholders of care management: heads of institutions and mostly middle managers in coordinating roles. In the second phase of the study, focus group interviews were conducted with non-executive carer workers. The purpose of the interviews was to explore their personal perceptions and narratives of care.

**Keywords:** care crisis, elderly care system, gender inequalities, construction of care, recognition of care works

## Introduction

The paper discusses the contemporary, particularly the Hungarian socio-political relevance of the care crisis. Sevenhuijsen (2003, 2004) already warned nearly two decades ago that care is a concept that is present and absent at the same time. Care-related tasks become policy agendas—in various areas of policy-making, from health and welfare system reforms to regulations of maternity benefits—through a variety of channels;

however, there is little room left for the ethics of care<sup>1</sup> in dominant policy approaches. In addition to demographic tendencies, public spending allocated to elderly care is on the decline, market-driven solutions are becoming prevalent, and competition for services is intensifying; as a result, by now, care has become “in need” (Melegh & Katona, 2020). In a narrow sense, the care crisis is understood as the growing gap between care needs and the resources available to meet them (Rottenberg, 2021). The concept of care crisis, however, does not only refer to the lack of available care, but it also incorporates the phenomenon that the low prestige and undervalued care tasks become the burden of families and, in particular, women, especially those working in health and social care. In a broader or even global interpretation, the crisis has rendered it visible that care regimes based on gender, regional, and class inequalities are unsustainable (Gregor & Kováts, 2020).

In Hungary—almost three decades after care work became professionalized—politicians question the professional nature of the tasks and responsibilities of social workers painfully often, which is reflected not only in the undervaluation of the profession but also in the chronic and severe underfunding of public social care. The wages in the social sector are the lowest in the national economy (Gyarmati, 2021, 2022). The care deficits are constantly growing: waiting lists for places in nursery homes are getting longer, and unfilled job vacancies are also increasing (Milankovics 2020). The present study was motivated by the phenomenon that elderly care in Hungary has been in a peripheral position for quite some time (Szabó, 2013), not only in comparison to other sectors—especially the health sector—but also within the similarly undervalued social care system. On the other hand, although social workers played a crucial role in the battle against the pandemic, government communication did not acknowledge their work, even at the level of symbolic gestures. At the beginning of the pandemic, at the time of curfews and lockdowns, essential workers (healthcare workers, shop assistants, etc.) were applauded all over the world. In Hungary, however, this kind of appreciation did not seem to be expressed toward social care workers (Csoba, 2020).

### **The Situation of Workers in Elderly Care**

The number and proportion of care workers in the labor force have been steadily increasing in all 27 member states of the European Union: rising by about 30% in a decade (Eurofound, 2020). Examining comparative data across countries, it becomes apparent that the proportion of workers depends primarily on access to services; namely, the wider the access,

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<sup>1</sup> According to the ethics of care, care and the need for care are both integral parts of our moral nature and human existence, so we experience both roles—albeit not at the same time—in the course of our life (Tronto, 1993; Bányai, 2008).

the higher the proportion of workers. The demographic composition of workers in elderly care is characterized by significant gender imbalance. According to the 2019 data, 81% of workers in the sector were female. Another apparent phenomenon is aging, the pace of which has accelerated over the past decade. Nurses and care workers immigrate to Hungary as well, however, in much smaller numbers than to Western European countries, where the proportion of migrant workers is rather high (Gyarmati, 2022).

In most EU countries, carers' wages are well below the average gross national wage for the whole economy. In Hungary—at a rate of 71%—workers in elderly care are among the lowest paid. Wages are typically higher in the public sector and in nursing homes, and, considering settlement size, in bigger cities. In elderly care, non-standard (atypical) working hours, such as part-time and shift work, are much more prevalent. Meanwhile, part-time employment in Hungary—due to the extremely low wages—is rather rare (Gyarmati, 2022). Furthermore, working in the sector carries significant physical risks, as it often involves lifting or moving clients. Nevertheless, the majority of workers in elderly care (71%) feel that their work is useful, while only around 20% are satisfied with their working conditions (Eurofound, 2020).

### **Background to the Case Study, Venue and Methods**

The venue of the qualitative case study was a mid-sized town in the Southern Great Plain in Hungary. According to the latest census data from 2011, the permanent population of the town is close to 30,000. The geographic position, location, and accessibility of the town are favorable. It is not afflicted by high unemployment rates, or is it a settlement with socio-economic and infrastructural disadvantages. The care institutes in the town also work as methodological centers in several segments of the social care system, with many good practices and professional innovations. It was my definite intention not to choose an institution in a deprived municipality when investigating the interference of the care crisis and the pandemic. Another reason for choosing this venue was the size and functions of the settlement: the town is big enough to accommodate all the types of services available within the social care system, while it is small enough to be explored in a relatively short period. This way, I had the opportunity to interview almost all the care workers in institutional elderly care.

The fieldwork and interviews started at the end of the first wave of the epidemic<sup>2</sup> (June 2020) and were completed during the upsurge of the third wave (March–April 2021). In the first phase of the study, I conducted ten semi-structured expert interviews with key actors

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<sup>2</sup> The fieldwork started the same day the day-care institutions reopened, having been closed for three months.

of care management in the town: the managers of two residential elderly care homes (one controlled by the local municipality and one church-run), the head of the Care Centre, the head of the Family Support Centre, the heads of the day clubs for the elderly (three people), the heads of the day centers for psychiatric patients and people with disabilities, and the head of the home help service. The head of the Care Centre assisted me in contacting the interviewees and provided the necessary background for the interviews. The interviews conducted with social workers in leadership positions revolved around three main topics:

- career profile, personal and professional mobility
- institutional framework—the impact of the coronavirus on the care system
- personal perceptions of the care crisis

In the second phase of the study, in the spring of 2021, I conducted three focus group interviews with direct care workers, altogether 18 people. There was some overlap between the respondents in the two phases using the different methods (4 people). The focus groups were professionally homogeneous: only full-time home care workers participated in the first focus group interview (7 people). In the second interview the heads of day clubs (4 people) participated, while in the third one with the direct workers of the same clubs: carers, community carers, occupational therapy and therapy workers (7 people).

The individual expert interviews lasted 60 minutes on average; however, I met some managers in key roles several times. The focus group interviews lasted longer: one and a half hours per session. Before submitting the manuscript in April 2022, I contacted some social workers in leadership positions to conduct a summative and evaluative discussion. All the participants agreed to be audio-recorded. The recordings were transcribed verbatim, with the circumstances of the interview and the most important nonverbal signs and events also documented. To preserve the anonymity of the research subjects, I only indicate the job title, gender, and age of the professionals referred to. As a first step when processing the individual and group interviews, I sought to understand the general meaning of the interviews by reading the transcripts several times. Afterwards, I organized content of the discussions into the main thematic units of the interview thread, then I prepared a list<sup>3</sup> of emerging topics that were not closely related to the questions of the interview outline and my preliminary assumptions. When identifying and summarizing meaning, my primary focus was to present the symptoms of the care crisis (blending family care and paid care jobs, work overload and the low prestige of the profession).

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<sup>3</sup> I tagged the transcript manually without content analysis software.

## Characteristics of the Sample

The nature of the investigation did not require the collection of socio-demographic data on the interviewees, just an inquiry into their professional experience and present job title. A characteristic of the aforementioned care crises is the horizontal segregation of care-related sectors and the feminization of the profession (Acsády, 2014; Gregor & Kováts, 2020; Gyarmati, 2021, 2022). Thus it is not surprising that women are overrepresented in my study as well (22 women and two men); what is more, both of the male interviewees work in leadership positions in the field of care. The vast majority of care workers in the sample belong to the 45–59-year-old age group, which matches the typical employer profile in the sector (Gyarmati, 2022). One in five respondents is younger than 35 years old, which broadly corresponds to the national data.<sup>4</sup> One in three respondents in the sample has been working at their present workplace for at least 25 years; however, it is difficult to determine whether this linear career path is due to care workers' commitment or their vulnerability resulting from lack of opportunities. The majority of care workers in leadership positions (eight out of ten) have tertiary-level vocational qualifications. Almost all of them are first-generation graduates and were already working part-time when studying for their diploma in distance education, which corroborates earlier research findings (Fónai et al., 2001; Vida, 2015). For them, joining the helping profession entailed a remarkable rise in status and significant social mobility. The home care workers' level of qualifications is slightly lower than that of the therapy and care workers employed in the day clubs. They usually work in the care field with a vocational training certificate for a "typical female job" (such as seamstress, shop assistant or nursing assistant), and they normally have a social carer and nurse qualification. However, it is noteworthy that continuous professional development and self-training are an important element of the organizational culture of the institute in the study, which is clearly linked personally to the head of the institute, who is a widely acknowledged professional not only in the town but also at county and national level. Her connections and social capital are matched with assertiveness and her ability to provide resources, which also creates opportunities for her staff to participate in professional training.

## The Impact of the Coronavirus on the Local Social Care System

Day centers for the elderly, psychiatric patients and people with disabilities were closed down by executive order on March 18, 2020. The head of the family support center signed his first director's order on the same day it was announced in Budapest that two infected persons had been identified. During the first wave, in this institution alone, 18 orders were issued,

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<sup>4</sup> In the survey cited earlier, 20% of the sample was younger than 40 (Gyarmati, 2021).

which were “molded into” a unified regulation, covering wide-ranging topics from the activities of work groups to how the daycare of employees’ children could be arranged. A recent nationwide survey (Gyarmati, 2022) confirms the experiences of the respondents: the procedures were not well wrought out, contradicted each other, and did not accord with either the existing regulations and the way institutes functioned or the state and condition of those in care. In both residential elderly care homes, curfews and visiting restrictions had already been imposed before the national state of emergency was declared. The institutes tried to prepare residents for the changes as fully as possible: they held resident meetings, informed relatives through Facebook groups, and put up a poster in the wards. In the elderly care home controlled by the local municipality, a so-called “lock system” was introduced at the very beginning of the pandemic, which regulated how the care workers enter the wards disinfected and in protective gear. The necessary protocol and procedure were established at the local level.

Within the local social care system, closing down the clubs providing daycare (for the elderly, psychiatric patients, and people with disabilities) brought about drastic changes in the lives of care workers and those in care as well. Losing their function and becoming empty, the clubs—in response to the abolition of serving lunch on the premises—had to set up a new structure that could manage the tasks of food delivery. It still has not been clarified why relatives were not allowed to pick up lunch in the yard of the institutes, nor whether this was an executive order or an independent decision made by the controlling authority. In the end, it was the local civil guard that was involved in delivering around 60 meals per day. In addition to the many volunteers, the staff of the sports hall also offered their help and delivered daily meals by bicycle. As half of the central kitchen staff was also sent home, the care workers of the day clubs did not only participate in food delivery but were also required to assist in portioning the meals. Switching to central lunch distribution created a new, unexpected task for the social workers (including those with several tertiary level diplomas and in leadership positions): they were given the extra task of washing up and disinfecting all the food containers that were used in daily deliveries, as the kitchen was already understaffed.

In the family support center, switching to home office brought about the most substantial structural change. The objective was to have carers spend half of their working hours in the institute and the other half at home. They kept in contact with their clients primarily through the online platform of the institute, and they also visited families whenever necessary, as they were allowed to enter the institute at previously agreed-upon times.

It was the sense of responsibility in the face of the emergency that contributed to the care workers' flexible adaptability and unquestioning acceptance of orders from above. It is indicative of the vulnerable position of helpers, working with the most vulnerable social groups themselves, that—according to the interviewed institute heads—the workers were more afraid of losing their jobs than of the pandemic. Therefore, it was extremely reassuring for them that the controlling local municipality promised that there would be no layoffs and nobody would be required to take compulsory unpaid leave, either. It was in residential care facilities that the pandemic was accompanied by the fewest operative structural changes; however, the months of lockdown and visitation restrictions required considerable efforts from them as well. These exertions included providing mental support and reassurance for residents with mood swings, informing relatives and establishing alternative ways of keeping in contact. Confinement took its toll mentally on the residents; in addition, keeping in contact by phone with elderly, demented patients is already rather difficult. The constant cleaning and disinfecting diverted the resources from caregiving, furthermore, military presence for the sake of performing disinfection meant extra work for the heads of the institutes. Overall, it can be concluded that all the actors of the institutional system operating at the venue of the study reacted proactively to the pandemic and successfully compensated for the shortcomings and dysfunctions of governmental pandemic management.

### **Working Time? Family Time?**

A pivotal presupposition of feminist care ethics is that caregiving tasks should be viewed as independent of gender—seen as both male and female—and location—not limited to the private sphere). My own research findings show the opposite: the majority of the respondents regard it self-evident that providing care is the task of women. There were responses that follow the well-known argumentation of the conservative/traditional narrative: “We are genetically coded like this” (club leader, female, 51), “This is how we have been socialised for decades or even centuries, since the time when there was no social safety net” (home care worker, female, 52), “It was nuns that used to do these tasks” (community care worker, female, 41). The interviewed care workers all accepted the traditional and asymmetrical share of housework as self-evident. Responses linked to the pragmatic narrative, such as “men are needed” especially for tasks requiring physical strength (bathing and lifting), were also frequent. However, as those in care are predominantly female, it would probably be more difficult for male care workers to build trust with them. At the same time, a number of counter-examples were also given, for example, that there are more and more male nurses in residential care homes and hospitals as well.

A so-called alternative narrative of care tasks, which is free from gender stereotypes, appeared only in the responses of care workers with tertiary-level diplomas and in leading positions, and its appearance showed no correlation with the respondents' age. Of the respondents in this group (3 people), two professionals have husbands who are also helpers by profession, and in their cases, it seems quite natural and self-evident to share household and childcare tasks. "My husband is also a social worker. And this is how he turns to people. At home, we don't do it like this is my job because I'm the woman because he does these jobs just like me" (club leader, female, 31).

The responses to the question of what care/caregiving means to them were fairly homogeneous. For the majority of care workers, the concept means an asymmetrical relationship, in which it is addressing emerging needs and demands and paying close attention to those in care that play a significant role. In this narrow interpretation, their everyday work experience and perceived professional norms mix with the roles they fulfil in the family, and for many of them, the two types of caregiving naturally blend. "We help them in their everyday life. Just like you care for your children or your father or mother when they are ill" (home care worker, female, 56). There was a care worker who considered maternal care as a primary model; thus, it was this role that she had incorporated into her paid work.

Maintaining boundaries is one of the most important professional competencies required of professional helpers. The majority of respondents in the focus group openly admitted that they "overcare" and do not even make attempts to follow the professional norms in this respect. "There are no rules, everything for those in care" (day carer, female, 48). One of the "without limits" narratives considers emotional involvement unavoidable. "I don't think it's possible in elderly care. We do get to love them, and I don't think there are boundaries" (day carer, female, 51). In the narratives of carers working with disabled people and in elderly day care, a common motif that can be identified is that they know their clients better than their close relatives do. As a result, they consider the physical proximity and touch of the people they care for to be natural. Professionals with tertiary-level diplomas make a conscious effort to keep their drive for "overcaring" under control. However, it is not only the lack of professional awareness that can be detected behind over-identification with the carer role but also the particular psychological needs of the helper.

Me, for example, and this is my personal opinion, I forget about my own troubles when I'm helping others. I'm concentrating on the other and not on myself. And really, this is true in the family too, and also at my workplace. (home carer, female, 46)



### **Leisure Time—Which Is Non-Existent**

The blending of the roles that carers need to take and the excessive penetration of caregiving tasks into helpers' personal life is not only due to the above-mentioned "overcaring" attitude of carers but also to the pressure exerted by work and life circumstances and helpers' self-exploitation. In the narratives, the expression "me time," which the interviewees heard at an internal training, emerges regularly, but only one care worker has managed to realize its practical application, who does not "have her meal while riding the bicycle" anymore. During the focus group interviews, several home care workers mentioned that they have no other choice but to work also when they are ill, otherwise, they could not provide the needed care for their clients. The head of the institute revealed that several of the care workers (13–15 people) could only lift certain weight limits, but they nevertheless accept the job. The vulnerability of those in care (elderly, psychiatric patients, or people with disabilities) is self-evident in the profession, but so is the vulnerability of care workers. Being constantly on the road, exposed to all kinds of weather, and being in poor health conditions, while physically and psychologically overloaded, all increase this vulnerability. Contrary to my preliminary assumptions, in none of the institutes did the care workers consider it a serious burden that they had to perform paid and unpaid care work at the same time. One of the reasons for this may be the higher average age of the workers in elderly care, while the other may be their low social status and extremely low self-advocacy skills. "If they had an older kid, the bigger child was looking after the smaller one. There was nobody who would go on unpaid holiday" (institute head, female, 47). In addition, most of the professionals in the sample find it natural that providing care at home, and in the family, is a female task, just as it is in the world of paid work. The principle they follow is that "we need to get it done." Therefore, it is not surprising that most of them—in that stage of their life when their children were small—could only rely on their mothers' help. Their relative contentment—or the lack of discontentment, to be precise—can be ascribed to the predictable working hours of daycare (compared to carers working in three shifts), which enables them to manage their tasks both at home and at work.

### **"It's as if We Didn't Even Exist"**

Even though the town where the field research was conducted is in a privileged position in many respects—the municipal leaders have always been supportive of the social sector, and the town has an institutional system that goes beyond its functional role and manifests professional innovation—all the interviewees expressed negative feelings about the lack of social recognition of the care profession. This resentment was especially palpable during the individual interviews following the first wave of the pandemic,

after the government had been expressing its official gratitude to everybody but professional helpers. The lack of thank-you gestures caused indignation even in those who were otherwise used to the invisibility of the social profession. "When there's a paid advertisement thanking the bus driver, but there is none to thank the social worker, well, that hurts" (club leader, female, 59).

In the second phase of the study, indignation was considerably less intense, as by that time, the healthcare system that had come under so much pressure that extra rewards and recognition for healthcare workers seemed justifiable even retrospectively. Another typical attitude appearing in addition to resentment was apathy, that is, accepting it with resignation that the situation cannot be changed. "I simply can't believe anymore that it will be any different ever; I just rather accept it. I know that it's not a good attitude, but I just don't know how to get out of it" (club leader, female, 44). It is probably this apathy that fuels the almost complete lack of collective representation in the sector. Furthermore, it is important to note that not only workers' indifference and lack of time contributes to the rejection of union membership but also, in many cases, pressure from the controlling authority (Gyarmati, 2022).

### **Summary**

When starting the study, I assumed that the current pandemic situation would magnify the symptoms of the care crisis and make them visible to the wider public. My presuppositions were only partially confirmed, as all actors of the institutional system in the field responded proactively to the pandemic, in many cases making up for the shortcomings and inconsistencies of governmental epidemic management. They established local protocols, purchased protective gear, equipment, and disinfectants from the institutional budget, involved civilians, and developed partnerships at the local level. Each care worker expressed how much it meant for them that the local community, the controlling authority, their direct supervisor, and colleagues supported and recognized them. The lack of state-level gestures expressing gratitude was, however, a reason for resentment, and/or triggered apathy among the respondents. The findings suggest that even a symbolic gesture would have made a significant difference for social care workers.

The results obtained through exploratory research cannot be generalized for all the professionals working in institutional care. However, they reveal that even the otherwise customarily undervalued field of social care is significantly segmented. An important finding of the study is that it is workers in direct, elderly care, especially those performing their tasks in home care, that experience the most disadvantaged

circumstances (concerning working conditions, psychological and physical overload, and prestige within the profession). Nevertheless, the present situation will become unsustainable in a few years due to the aging of workers, the lack of replacement, poor working conditions, low wages, and a general lack of respect for social work. The consequence will not only be a violation of the rights of both clients and workers, but also the further deepening of the care crisis.

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